Prior Authorization Approval Criteria

Diflucan (fluconazole)

Generic name:	Fluconazole
Brand name:	Diflucan
Medication class:	Antifungal
FDA-approved uses:	Oropharyngeal, esophageal, and systemic candidiasis; cryptococcal meningitis.
Usual dose range:	100 mg to 400 mg per day
Duration of therapy:	2-12 weeks depending on fungal infection and disease state.

Criteria for use *(bullet points below are all inclusive unless otherwise noted)*:

- Clinically documented oropharyngeal, esophageal or systemic candidiasis.

OR

- Clinically documented cryptococcal meningitis.

OR

- Prophylaxis of candidiasis in bone marrow transplantation

OR

- For dermal fungal infections (not including onychomycosis) where topical antifungal agents are considered first-line therapy:
    - Patient must have failed/intolerant to both an OTC and Rx topical antifungal agent used for an appropriate length of time
      OR
    - Patient has an extensive infection involving areas too large to reasonably use a topical agent
      OR
    - Patient has a chronic, recalcitrant infection
      OR
    - Patient is immunocompromised

Contraindication: Hypersensitivity to fluconazole.

Not approved if:

- Patient does not have clinically documented fungal infection, except in prophylaxis of candidiasis in bone marrow transplantation.
- Patient has vaginal yeast infection
- Unable to obtain liver function tests
- Patient has any contraindication to the use of fluconazole
- Patient does not meet the above-stated criteria

FCHP Pharmacy and Therapeutics Committee approval: ____

Date: ______________________ Adopted: 11/15/04